Colorado Department of Labor and Employment
Unemployment Insurance Operations
P.O. Box 400, Denver, CO 80201-0400
303-318-9000 (Denver-metro area) or 1-800-388-5515 (outside Denver-metro area)

Print or type complete name and address below

| |
|---|
| Date |
| Social Security Number (last four digits)<br>XXX-XX- |
| Due Date |

# MEDICAL STATEMENT

By signing your name in **Section 1**, you authorize your physician or medical practitioner to provide information to Unemployment Insurance (UI) Operations. **Section 2** is to be completed by your physician. Complete and sign **Section 3** only **after** your physician has completed **Section 2**. By signing your name in this section, you are confirming that you understand the information provided by your physician. You are responsible for returning the form.

## Section 1. Consent to Release Medical Information

| | |
|---|---|
| I consent to release the requested information for the purposes of processing my claim for UI benefits with the understanding that the information is for use in determining my eligibility and entitlement for UI benefits in accordance with the Colorado Employment Security Act 8-73-108 (4)(b). | |
| Claimant Signature | Date |

## Section 2. (To be completed by physician or medical practitioner only)

The person named above has applied for UI benefits. Obtaining the information requested below will help UI Operations make a determination of eligibility and entitlement. Any alteration must be initialed. Your cooperation in providing this information is appreciated. **The completed form must be returned to UI Operations by the patient**.

| Medical Condition (State in layperson terms.) | Dates of Treatment | |
|---|---|---|
| | From | To |

Is the patient able to return to work? ☐ Yes ☐ No

If the patient is able to return to work:
On what date was the patient able to return to work? _____

Are there any restrictions that would keep the patient from returning to his or her usual occupation? ☐ Yes ☐ No
If **Yes**, please list the restrictions (e.g., lifting restrictions, part-time work only, light-duty work)
_____

If the patient is unable to return to work:
On approximately what date will the patient be able to return to work? _____

| | | |
|---|---|---|
| Additional Comments | | |
| Physician Address | | Telephone Number |
| Physician Name | Signature | Date |

## Section 3.

| | |
|---|---|
| I have read and understand the above statement provided by my physician. | |
| Comments | |
| Claimant Signature | Date |